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In the Matter of

DANFORTH C. WALDEN, II
Claimant
v.
DYNCORP TECHNICAL SERVICES/
INSURANCE CO. of the STATE of PENN.
Employer/Carrier
And
DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

Case No. 2005 LDA 00037
File No. 02-136090

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Decision and Order

This matter arises pursuant to a claim for benefits filed under the Defense Base Act by Danforth Walden of Winter Haven, Florida. On January 5, 2004, Walden suffered an abrasion to his right knee while setting up a camp in a jungle area around Larandia, Columbia. CX 11 at 4-5, 24-25. At the time of the injury, he was involved in the war on drugs, working as an armaments technician for Dyncorp Technical Services, a government contractor. Several days after he skinned his knee, he noticed insect bite marks around the wound. As a result of the injury and subsequent insect bites, he experienced pain and swelling. He reported the injury to a search and rescue technician and his supervisor; but as a consequence of his remote location, he received no treatment for approximately two weeks. CX 11 at 6.

When his rotation ended, Claimant was given antibiotics for an infection, and later, back in the states, he was diagnosed and treated conservatively for chondromalacia with an articular defect in the patellofemoral joint. He lost no time from work and sustained no loss of wage earning capacity. Tr. 13. The parties

have stipulated that his average weekly wage is $1,183.39. Tr. 21. Walden reached maximum medical improvement, Tr. 17, and now claims entitlement to a scheduled award for a 60% disability to his right lower extremity and authorization for continuing medical treatment. Tr. 18; Cl Br. at 21. Claimant still works for Dyncorp. Cx 11 at 23.

Employer does not dispute that Claimant sustained a knee abrasion and was subsequently bitten by an insect, most likely a spider, Ex 2; Ex 3; Ex 4, but it disputes the impairment rating Claimant received, and it denies that his present condition is due to the injuries he sustained at work in the Columbian jungles. Ex 4; *See also*, Emp. Post-hearing Br. Accordingly, Dyncorp denies that Walden is entitled to any of the benefits provided by the Defense Base Act.

Background

Because the etiology of Claimant's current condition is a key issue in this proceeding, we turn first to circumstances which gave rise to the injury both parties agree did occur. At the time of the hearing, Walden was back on duty in Columbia, and his deposition testimony was received into the record without objection. Cx 11. Employer does not challenge his credibility in describing either the injuries he sustained or the symptoms he reported.

The record shows that Claimant, an honorably discharged marine, was the lone member of an advance party initially assigned to prepare a jungle facility near Larandia, Columbia. On his first day at the site, he was kneeling on a vinyl mat using an air hose, when he sustained an abrasion on his right knee. Cx 11 at 5-6, 15-16. Within a day or two, the wound became infected, Cx 11 at 5, producing discoloration, pus, and a detectable odor. Cx 11 at 8. Shortly thereafter, he noticed three marks around the wound which he believes were left by a spider that bit him while he slept. Cx 11 at 5, 9. He noted that the jungle in the vicinity of his worksite was populated by both brown recluse spiders and tarantulas. He did not, however, see the insect that bit him. Cx 11 at 5.

Apparently, the spiders in the jungle around Larandia are impressive. Claimant reflected on his experience: "Well when your reading a book, and you're the only one in the building, and the spider goes by this doorway and it leaves a shadow, yeah, they're scary." Cx 11 at 10. In any event, it seems the consensus of those who observed the bites agreed they were delivered by a spider of some type, Cx 11 at 9, 16, and the bites produced prodigious swelling around the right knee that Claimant described as the size of a cantaloupe. Cx 11 at 5, 8, 15.

Although Claimant sought no treatment for the initial abrasion, Cx 11 at 7, he contacted a search and rescue technician for treatment when he noticed the infection, Cx 11 at 8, and again sought help on several occasions after the spider bites. Cx 11 at 5, 8-9, 13. Following the abrasion and bites, Claimant experienced swelling, fever and chills, Cx 11 at 10, soreness and stiffness in the joints of his arms, legs and back, Cx 11 at 10-11, and although he continued to work, he experienced considerable pain in his right knee that caused him to limp. Cx 11 at 11-14. Ten days to two weeks later, he felt fluids in his right knee and the wound was still excreting pus. Cx 11 at 14-15.

Claimant received no actual treatment or medication for his wounds until he was evacuated to Tolemaida military base at the end of his rotation over a week or two later. Cx 11 at 6, 13, 15. At Tolemaida, he was given Amoxicillin by the Employer's search and rescue supervisor, Billy Pyle, and the record includes no report of the medical provider's evaluation or diagnosis of the active infection being treated. Cx 11 at 16. After returning home, Claimant continued to take the antibiotic. He noticed that the swelling subsided but the infection remained under the skin around his knee. Cx 11at 17. Although the knee remained painful, Claimant did not seek further treatment during the eleven or twelve days he was home resting before his next rotation. Cx 11 at 17-18.

After about three or four months, the swelling subsided and the discoloration faded, but the stiffness remained and he experienced an itching sensation. Over time, his knee cap became more painful, and he began to experience popping and cracking in the knee. Cx 11 at 19-21, 25. Walden denies any previous injury or pain in his right knee. Cx 11 at 18, 24. He eventually filed a claim under the Defense Base Act after returning home from subsequent rotations.

Medical Evidence
I.

Upon the Employer's referral, Walden met with Dr. James Melton, an orthopedic surgeon, on July 20, 2004. Cx 11 at 22; Cx 2. Dr. Walden obtained a history of the injury and symptoms, performed a physical examination, and reviewed an x-ray. Based upon his evaluation, Dr. Melton diagnosed both post-traumatic chondromalacia of the right knee which Dr. Melton defined as a disintegration or deficit in the cartilage, and synovitis/cellulites of the right knee due to spider bites. To gain a better understanding of Claimant's condition, he ordered an MRI. Cx 2. Two days later, Dr. Melton received the MRI results from

Dr. Hornsby. The MRI confirmed the initial diagnoses, but also revealed, in addition, chondromalacia with an articular defect of the lateral femoral condyle where it articulates with the patella. Cx 6; Cx 3. Dr. Melton placed Walden at MMI, but noted that Claimant may require surgery in the future, and using the Florida Guide he rated him at 6% PPI of the whole person, Cx 2; Cx 3. By letter dated July 29, 2004, Dr. Melton opined that Claimant's impairment is "100% causally-related to the industrial injury of 1/05/2004 and subsequent complications following that injury." Cx 3; Ex 6.

On October 25, 2004, Dr. Melton was requested by Employer to confirm his impairment rating under the AMA Guides 4th edition.[1] He reported that Claimant had a 22% permanent impairment of the lower extremity equating to 9% of the whole person. Cx 4; Ex 6. Dr. Melton imposed no work restrictions, but anticipated that Claimant is likely to require total knee replacement in the future. Cx 4. Claimant thereafter sought additional treatment with Dr. Melton, but the Carrier declined to authorize it. Cx 7, 8, and 9.

Dr. Melton was deposed on June 7, 2005. His deposition, identified as CX 5a is, by agreement of the parties at the hearing, Tr. 7-8, substituted for Cx 5. After reviewing his reports, Cx 5a at 1-10, Dr. Melton explained that in assessing the etiology of the articular defect in the lateral femoral condyle he was impressed that Claimant had no history of any problems with the knee before the episode in January of 2004, and if the incident history is correct, he believes the industrial accident caused the articular defect. Cx 5a at 10-12; 14-15.

Dr. Melton also revised his impairment rating based upon the AMA Guides, 5th edition. Id. He again referred to the table related to arthritis induced cartilage intervals that, in his opinion, provides a situation analogous to Claimant's. Cx 5a at 16; Cx 10, page 544, Table 17.31. He explained that the table addresses the thickness of cartilage or the distance between bones. He explained further that he applied this guide because the MRI and grating of the knee on clinical examination showed that: "two bony surfaces within the crater of the chondromalacia…were rubbing against each other," and at that point had basically a zero millimeter interval. Cx 5a at 16-17. He did not, he defended, initially discuss the narrowing of the cartilage when he first reviewed the MRI because the issue of narrowing "is strictly to try to apply the guides," Cx 5a at 31-32; whereas the chondromalacia

[1] At the hearing, the parties stipulated that the AMA guides 5th edition are the applicable guides in this proceeding. Tr. 18-19; Cx 10 AMA 5th. Application of those guides were addressed in the depositions of both Dr. Melton and Dr. Halperin.

defect revealed on the MRI usually means the cartilage surface is "totally eroded' in the area of the defect. Cx 5a at 36.

Dr. Melton noted that the AMA guides are not exact, and in many cases such as this situation, they require the practitioner to apply the guide that most closely approximates the condition the patient presents. Cx 5a at 17, 20, 30. At one point, in searching for a condition close to Claimant's, he considered analogizing it to a total menisectomy. Cx 5a at 38. Eventually, he decided that the table he actually used most closely approximated Claimant's condition. As a result, he concluded that Walden has a 50% impairment of the lower extremity as a consequence of the zero cartilage interval due to the articular defect and a 20% impairment due to the patellofemoral joint problem. Cx 5a at 17-18. He explained that he picked zero millimeters spacing because the MRI showed that the slick surface of the bone was gone resulting in bone on bone contact, not across the entire knee joint, but on one side where there is an absence of cartilage between the lateral femoral condyle and the patella. Cx 5a at 34-35. Dr. Melton further reasoned that, assuming Claimant had an asymptomatic preexisting degenerative knee defect, the injury he suffered could produce an aggravation resulting in a permanent impairment. Cx 5a at 40-41. In Dr. Melton's opinion, however, Claimant's current complaints of cracking in the kneecap and pain upon twisting of the right knee are consistent with conditions he diagnosed, and he believes Claimant should be further evaluated by a physician. Cx 5a at 25.

II.

On November 16, 2004, Employer sent Claimant to Dr. Lawrence Halperin, an orthopedic surgeon, Ex 8, for an independent medical examination. In an unsigned report in evidence at Ex 7, Dr. Halperin notes that he reviewed Claimant's injury and symptom complaints, the medical history, and medical records, including Dr. Melton's records and diagnostic tests. In addition, Dr. Halperin examined Claimant and reviewed x-ray films of both knees. Ex 7. In his opinion, the abrasion and soft tissue infection had resolved except for a slight discoloration, but he agreed that Claimant has a patellofemoral articular defect. Ex 7. The articular defect, Dr. Halperin commented, raises two questions.

Reflecting upon Dr. Melton's impairment rating, Dr. Halperin disputed the use of the AMA Guide 4th edition, pg. 3/83. He noted that Dr. Melton used Table 62 which is associated with arthritis impairments based on x-ray-determined cartilage intervals, and he noted that Claimant's x-ray showed a normal cartilage interval. Ex 7 at 000012.

Dr. Halperin also addressed the etiology of Claimant's current condition. Ex 7 at 000013. He noted that an articular defect of the patellofemoral joint can arise as a consequence of trauma or the aging process. If it occurs acutely, he would expect a trauma sufficiently significant to knock off a piece of the cartilage. Id. In this instance, there was merely an abrasion which did not, in Dr. Halperin's opinion, produce sufficient trauma. In addition, the infectious bite, Dr. Halperin observed: "was never thought to be in the joint…," and, in any event, he explained that: "Soft tissue infection in front of the patella should not cause a femoral condyle articular defect." Id. Accordingly, Dr. Halperin concluded that the articular defect is unrelated to the industrial accident and no impairment rating should be attributed to it. Id.

On June 21, 2005, Dr. Halperin was deposed. Ex 10; Tr. 8. He testified that,in addition to the information he reviewed in preparing his report, he subsequently reviewed the deposition of Dr. Melton and glanced at Claimant's testimony. Ex 10 at 8. Based on the information available to him, Ex 10 at 8-14, Dr. Halperin explained that the articular defect noted in the MRI is located at the bottom front of the femur where it rubs against the kneecap. In the area of the defect, the cartilage "is gone." Ex 10 at 14. The most common cause of an injury of this type is, according to Dr. Halperin, acute traumatic injury like those experienced by football players and auto accident victims. Ex 10 at 14-15. In other cases, the defect appears secondary to a degenerative process or an old injury. Ex 10 at 15.

In this instance, Dr. Halperin noted the problem was not suspected until it was detected by the MRI, and as a result, there is no way to tell whether it resulted from an old injury or a degenerative process. Ex 10 at 15. He was clear, however, that the defect was not the result of the abrasion injury Claimant sustained, because the degree of trauma required to knock off a piece of cartilage would be very painful, and the victim would know it immediately. Ex 10 at 16-17. Dr. Halperin also opined that the abrasion and subsequent insect bite resulted in an infection, but the only residual from the infection, in his opinion, is a slight discoloration. Ex 10 at 17-18.

In Dr. Halperin's professional judgment, Walden's defect is due to a degenerative process or an old injury, because, although an infection in the joint can cause cartilage damage, he believes the infection, in this instance, was in the knee not the knee joint. Ex 10 at 19, 38. He acknowledged, however, that if pus "did fill up the knee joint" then damage could result. Ex 10 at 20. Still, had the

knee joint been infected, Dr. Halperin opined that Claimant would have been unable to function and aggressive treatment would have been required to remove pus from the joint either by needle or surgery. Ex 10 at 20-22. Left untreated long enough, Dr. Halperin acknowledged that cartilage damage could occur, but he would expect the entire joint cartilage to thin diffusely, not present as a small area of defect. Ex 10 at 20-21. He observed that; "…[I]f you've never been treated surgically, just with antibiotics after a while, there is no way you get a normal joint after a septic knee…." Ex 10 at 22. Further, the antiobiotics needed to cure a septic joint are usually administered through an IV in the hospital. Thus, Dr. Halperin deems it unlikely that the antibiotic pills Claimant took would clear up an infected knee joint, Ex 10 at 23, and if used would probably leave the knee damaged. Ex 10 at 23. Further, it is, in Dr. Halperin's opinion, equally unlikely that Claimant would have been able to return to work as quickly as he did if his joint had been infected. Ex 10 at 48-49.

Dr. Halperin reasoned further that Claimant's experience did not appear "right" for an infection in the knee joint, but if he did have a cartilage problem, "the cartilage problem we're talking about -- if I am wrong and was in the knee -- wouldn't come from this type of thing, it comes from something else." Ex 10 at 22-23.

Turning to Dr. Melton's impairment rating, Dr. Halperin considered it "inappropriate," Ex 10 at 24, and based on the wrong AMA Guide. Ex 10 at 27. He noted that Dr. Melton used Guide for arthritis in the knee, a condition that involves the cartilage between the femur and the tibia, not the femur and the patella. Ex 10 at 28-29. Further, he noted that a 20% rating for loss of cartilage would be for a total loss of cartilage between the femur and tibia where weight is borne and Claimant's knee is normal. Ex 10 at 29-30. Claimant's articular defect, it appears, is not in a weight bearing area. Ex 10 at Ex 10 at 30.

According to Dr. Halperin, based on the AMA Guide 5th edition, Table 17-33, Claimant has either a 3% whole person impairment and a 7% impairment to the lower extremity or a zero impairment, "and it could be argued both ways."[2] Ex 10 at 24-26. He agreed with Dr. Melton that the Guides do not specifically address Claimant's condition, Ex 10 at 25, but he believes the Table he used for a patella

[2] Dr. Halperin noted that AMA Guide 5th Edition provides diagnosis-based impairment ratings, not ratings based on diminished motion, diminished strength, or diminished ability to function which, of course, are the factors usually considered in assessing an injured worker's ability to earn a living. Nevertheless, the parties stipulated that these are the applicable guides in this proceeding, Tr. 18-19, and Dr. Halperin observed that based on a diagnosis-based impairment rating, no rating is specifically assigned under the AMA Guides 5th edition to Claimant's condition; so Dr. Halperin contends his rating, arguably, should be zero. Ex 10 at 25-26.

subluxation with residual instability evaluates a worse condition than Claimant suffers. Ex 10 at 25. He testified that Claimant has no decreased range of motion, no atrophy, no loss of strength, no gait derangement, no nerve damage, Ex 10 at 26-27, and his activities are not limited. Ex 10 at 36. Dr. Halperin further disagreed with Dr. Melton's rating which combined the knee and patellofemoral joint. In Dr. Halperin's opinion, if you the rate the knee at the maximum, the patellofemoral joint should not be rated separately, but he acknowledged that others may disagree, Ex 10 at 45, and assuming the two are combined for a zero millimeter interval, the combined 50% and 20% on the combination chart equates to a 60% rating. Ex 10 at 46.

In summary, Dr. Halperin agreed that Claimant's symptoms of pain upon twisting of the knee and crepitus, grinding, and popping should be evaluated by an orthopedic, Ex 10 at 41, and he agreed that if the residuals of the accident were not permanent, they should not last a year and a half. Ex 10 at 42. He concluded, however, that Claimant's articular defect was not due to the industrial accident. Ex 10 at 32.

Discussion

Compensability of the Injury

The threshold issue in this proceeding is whether Claimant sustained a scheduled, work-related permanent partial injury to his right knee. Dyncorp maintains that Walden skinned his right knee and was subsequently bitten by a spider around the wound which became infected temporarily, but those injuries have resolved without causing any permanent harm. The articular defect which is a permanent condition in the cartilage around the right patella is not, according to Dyncorp, related to anything that happened at work. Claimant disagrees. He contends that the injury to his knee caused a 60% permanent partial disability of his right lower extremity which entitles him to a schedule award and medical treatment. Considering these issues, we turn first to the etiology of Claimant's condition.

Section 20 Presumption

Section 20(a) of the Act provides Claimant with a presumption that his condition is causally related to his employment if he shows that he suffered a harm and that employment conditions existed or a work accident occurred which could have caused, aggravated, or accelerated the condition. *See,* Merill v. Todd Pacific

Shipyards Corporation., 25 BRBS 140 (1991), *aff'd*, 892 F.2d 173, 23 BRBS 12 (CRT) (2d Cir. 1989). It is well settled that a work related aggravation of a pre-existing condition is an injury pursuant to §2(2) of the Act. Gardner v. Bath Iron Works Corporation., 11 BRBS 556 (1979), *aff'd sub. Nom.*, Gardner v. Director, OWCP, 640 F.2d 1385 (1st Cir. 1981); Preziosi v. Controlled Industries, 22 BRBS 468 (1989); Janusziewicz v. Sun Shipbuilding and Dry Dock Co., 22 BRBS 376 (1989) (decision and order on remand); Johnson v. Ingalls Shipbuilding, 22 BRBS 160 (1989); Madrid v. Coast Marine Construction, 22 BRBS 148 (1989). Moreover, the employment-related injury need not be the sole cause or primary factor in a disability for compensation purposes; if an employment-related injury contributes to, combines with, or aggravates a pre-existing disease or underlying condition, the entire resultant disability is compensable. Strachan Shipping v. Nash, 728 F.2d 513 (5th Cir. 1986); Independent Stevedore Co. v. O'Leary, 357 F.2d 812 (9th Cir. 1966); Kooley v. Marine Industries Northwest, 22 BRBS 142 (1989); Mijangos v. Avondale Shipyards, Inc., 19 BRBS 15 (1986); Rajotte v. General Dynamics Corp., 18 BRBS 85 (1986). Furthermore, a claimant is not required to introduce affirmative medical evidence establishing that the working conditions in fact caused the alleged harm, but he must be go beyond "mere fancy" and show the existence of working conditions which could conceivably cause the harm alleged. Sinclair v. United Food & Commercial Workers, 23 BRBS 148 (1989). As noted above, in this instance, there is medical evidence which satisfies the above criteria. An MRI establishes the presence of the chondromalacia of the right patella with the articular defect, and Dr. Melton has attributed this condition to the work-related skin abrasion and subsequent spider bites. Employer's protestations to the contrary notwithstanding, the evidence is sufficient to invoke the presumption in Section 20(a).

Rebuttal

Upon invocation of the presumption, the burden shifts to employer to rebut the presumption. The burden varies from circuit to circuit, but this matter arises within the jurisdiction of the Eleventh Circuit Court of Appeals which has held that the presumption is not rebutted unless there is direct, concrete evidence ruling out a causal relationship. Brown v. Jacksonville Shipyards Inc., 893 F.2d 294, 23 BRBS 22 (CRT) (11th Cir. 1990). Interpreting Brown, the Benefits Review Board has determined that a physician's unequivocal testimony regarding the lack of a causal nexus, rendered to a reasonable degree of medical certainty, is sufficient to sever the causal link between claimant's employment and his harm. O'Kelley v. Dep't of the Army/NAF, 34 BRBS 39 (2000).

While the evidence fails to rebut the presumption that Claimant injured his right knee at work, Employer's evidence does rebut the presumption that the articular defect was caused by the industrial accident whether its burden is to "rule out" causation under Brown or merely adduce "substantial evidence to the contrary," *see*, Conoco, Inc. v. Director, 194 F.3d 684, (5th Cir. 1999). Thus, Dr. Halperin's unequivocal assessment that Claimant's current condition is unrelated to his on-the-job injury is sufficient to vitiate the presumptive nexus under Brown and O'Kelley or Conoco.

Accordingly, the presumption having been triggered and rebutted, the record as a whole must be evaluated to determine whether Claimant has sustained his burden of establishing the etiology, nature and extent of the permanent condition which now affects his right lower extremity. MacDonald v. Trailer Marine Transport Corp., 18 BRBS 259 (1986), aff'd mem. sub nom. Trailer Marine Transport Corp. v. Benefits Review Board, 819 F.2d 1148 (11th Cir. 1987); *See*, Del Vecchio v. Bowers, 196 U.S. 280 (1935 U.S. Industries/Federal Sheet Metal, Inc., v. Director, 455 U.S. 608, 615 (1982);); Avondale Shipyards, Inc., v. Kennel, 914 F.2d 88, (5th Cir. 1990); Trask v. Lockheed Shipyard & Constr.Co., 17 BRBS 56, 59 (1980).

Etiology
I.

The task of determining the cause of the articular defect in Claimant's right knee is primarily a medical endeavor undertaken, in this case, by two highly qualified orthopedic surgeons, both of whom, incidentally, saw Claimant upon referral from the Employer. In Dr. Melton's opinion, Walden's current condition is "100% related" to his work activities in the Columbian jungles. Dr. Halperin disagrees. In his opinion, the articular defect is unrelated in any way to the abrasion and spider bites Claimant described. Thus, two equally qualified physicians have rendered diametrically opposite opinions regarding the etiology of Claimant's condition. Under these circumstances, we need assess the relative evidentiary weight each opinion may be accorded. Cardillo v. Liberty Mutual Ins. Co., 330 U.S. 469, 477 (1947); John W. McGrath Corp., v. Hughes, 289 F.2d 403 (4th Cir. 1961); Pimpinella v. Universal Maritime Services, Inc., 27 BRBS 154 (1993); Williams v. Newport News Shipbuilding and Dry Dock Co., 17 BRBS 61 (1985).

The record shows that Dr. Melton predicated his etiology evaluation upon a full review of Walden's injury and symptoms history, the results of a physical

examination, and review of x-ray and MRI results. He initially diagnosed both post-traumatic chondromalacia of the right knee and synovitis/cellulites of the right knee due to spider bites, and after receiving the MRI findings he diagnosed, in addition, the chondromalacia with an articular defect of the lateral femoral condyle where it articulates with the patella. At his deposition, Melton explained that, in assessing the etiology of the articular defect, he was impressed that Claimant had no history of any problems with the knee before the episode in January of 2004, and he concluded that, assuming the incident history is correct, and this record confirms that it is accurate, the industrial accident caused the articular defect. He further opined that, assuming Claimant had an asymptomatic pre-existing degenerative knee defect, the injury he suffered could produce an aggravation resulting in a permanent impairment. In Dr. Melton's opinion, Claimant's current complaints of cracking in the kneecap and pain upon twisting of the right knee are consistent with work-related conditions he diagnosed.

Employer argues, however, that Dr. Melton's etiology assessment is deficient because he failed to describe a mechanism that would account for the articular defect revealed by the MRI. Dr. Melton agreed that a defect like Claimant's is normally caused by a severe traumatic injury akin to sledgehammer blow, and Employer notes that there is no evidence of such acute trauma in this record. Emp Br. at 6, 8. Employer argues further that, while Dr. Melton believed the infection was the etiology of the defect, he never actually diagnosed an active infection. He accepted the presence of an injury-related infection by history, Emp Br. at 7, and then, according to Employer, failed to explain how the infection damaged only a small part of the cartilage or how Claimant was able to continue to work with a septic joint. Emp. Br. at 11. Finally, Employer is critical of Dr. Melton for basing his opinion on causation, in part, on Claimant's: "history of never having any problems with the knee…" before the January, 2004 incident in the Columbian jungles. As Employer describes it: "this *res ipsa loquitur* approach…. is insufficient to establish industrial causation." Emp Br. at 7.

The record shows that Dr. Halperin, like Dr. Melton, formulated his etiology evaluation based upon the results of a physical examination, and a full review of Walden's x-ray, MRI results, and Dr. Melton's records relating to Claimant. He also perused Claimant's deposition testimony regarding the injury and symptoms history. In his opinion, the abrasion and soft tissue infection had resolved except for a slight discoloration, but he agreed that Claimant has a patellofemoral articular defect.

At his deposition, Dr. Halperin testified that the articular defect noted in the MRI is located at the bottom front of the femur where it rubs against the kneecap. In the area of the defect, the cartilage "is gone." The most common cause of an injury of this type is, according to Dr. Halperin, severe acute traumatic injury, but he is aware of other cases in which the defect appears secondary to a degenerative process or an old injury that may have gone unnoticed.

In this instance, Dr. Halperin noted the problem was not suspected until it was detected by the MRI, and as a result, there is no way to tell whether it resulted from an old injury or a degenerative process. He was clear, however, that the defect was not the result of the abrasion injury Claimant sustained because the degree of trauma required to knock off a piece of cartilage would be very painful, and the victim would know it immediately. Dr. Halperin also opined that the abrasion and subsequent insect bite resulted in an infection, but the only residual from the infection is a slight discoloration.

Dr. Halperin suggested that an infection in the joint can cause cartilage damage, but he believed the infection, in this instance, was in the knee not the knee joint. He reasoned that had the knee joint been infected, Claimant would have been unable to function and aggressive treatment would have been required to remove pus from the joint either by needle or surgery. Left untreated long enough, Dr. Halperin acknowledged that cartilage damage could occur, but he would expect the entire joint cartilage to thin diffusely, not present as a small area of defect. In addition, the antibiotics needed to cure a septic joint are administered through an IV in the hospital, and Dr. Halperin deems it unlikely that the antibiotic pills Claimant took would clear up an infected knee joint. Further, it is, in Dr. Halperin's opinion, equally unlikely that Claimant would have been able to return to his work so quickly if his joint had been infected.

Dr. Halperin reasoned further that Claimant's experience did not appear "right" for an infection in the knee joint, but if he did have a cartilage problem, "the cartilage problem we're talking about -- if I am wrong and was in the knee -- wouldn't come from this type of thing, it comes from something else," and, on balance, he believed that Walden's defect could be due to a degenerative process or an old injury.

Claimant contends that Dr. Halperin's etiology assessment is deficient, because he failed to consider relevant aspects of Claimant's history. For example, Dr. Halperin agreed that an infection caused by an insect bite could produce an articular defect like Claimant's, but it would be extremely painful and produce pus.

This, Claimant insists, is entirely consistent with his history both in respect to the pain he experienced and the development of pus in the wound. Cl. Br. at 12-13. Claimant also asserts that Dr. Halperin acknowledged the Claimant experienced some cartilage thinning as a result of infection but failed to assess the actual amount of thinning. Cl. Br. at 13. Finally, Claimant argues that, unlike Dr. Melton, Dr. Halperin failed to consider the real history involved in this matter or the aggravation of a pre-existing degenerative process which Dr. Halperin believes may have existed.

II.

Upon consideration of the divergent etiology assessments by the two physicians who have addressed this issue, I have concluded that Dr. Melton's opinion is entitled to greater evidentiary weight than the contrary opinion of Dr. Halperin. While an employer need not establish an alternative etiology, the suggestion that Claimant's articular defect is a consequence of an old, but severe trauma or other injury that degenerated over time, is speculative and unsupported by the evidence in this record. Nor is it likely that Claimant would have forgotten had such an injury occurred. Dr. Halperin, in describing the force needed to knock off a piece of cartilage and the excruciating pain that would result, articulated an experience that would not likely be forgotten by anyone who went through it. In this, instance, Claimant's medical history included an injury to his left knee, but he had no history of any injury to his right knee.

Dr. Halperin also concluded that the defect was not caused by the infection, because an infection would produce pus in the joint, and Claimant's infection was localized and did not produce pus. Further, he noted that it was not treated in a way the medical community would ordinarily treat a septic joint, that the damage to the cartilage was localized and did not involve the entire cartilage, and that Claimant's pain levels did not rise to the level of a septic joint as indicated by the fact that Claimant was not completely debilitated and was able to return to work too quickly. The record shows, however, that Claimant's knee swelled to the size of a cantaloupe, and that the infection did produce pus. The record further shows that Claimant experienced a great deal of pain but endured it. Yet, he had few other choices.

While a septic joint might be sufficiently painful to incapacitate the average person under ordinary conditions, Claimant was virtually left on his own, untreated, for over a week in a jungle environment. He reported the incident and requested the Employer's assistance; however, the Employer was not particularly

helpful. Thus, Dr. Halperin infers that it is unlikely that infection had penetrated the knee joint, because it would have completely debilitated Claimant. The record shows, however, that Claimant, an ex-marine, endured sever pain and a knee that swelled prodigiously. Still, he was not as debilitated as other patients Dr. Halperin had seen with infected knees.

The evidence, nevertheless, demonstrates that Claimant was in the type of environment that would tend to encourage one to endure a bit more pain than usual and stave off the onset of debilitation that might prove overwhelming in a different setting. Under these circumstances, Dr. Halperin's failure to consider Claimant's apparent pain threshold and the functional necessities imposed in an environmental context which his ordinary patients never experience renders his comparison of the reactive responses he has observed in Orlando, Florida, and would, therefore, expect Walden to exhibit, inconclusive.

Dr. Halperin further testified that an articular defect like Claimant's is usually due to sever trauma or lesser trauma and degeneration, but there is no evidence of any history of right knee injury at all. He indicated that a severe infection could cause a defect like Claimant's, but it did not appear that Claimant had pus in his knee or an infection in the joint. The record does show, however, that Claimant reported both pus and an odor emanating from the infection.

Dr. Halperin testified that he would also expect a knee joint infection to thin and damage the entire cartilage not just a localized piece of cartilage. He acknowledged that Claimant "may have had chondromalacia at one point in time" but believes it is unrelated to the injury at work, because Claimant "never had the trauma to cause it." Yet, the MRI results, as interpreted by Dr. Hornsby, showed not only the defect of the lateral femoral condyle where it articulates with the patella, but also chondromalacia with reactive bone marrow. Here again, however, Dr. Halperin explains that the work-related injury did not produce sufficient trauma to cause chondromalacia, but he did not assert that only trauma could cause it nor did he deny that an infection could produce chrondromalacia in the absence of any trauma history to the right knee.

Dr. Halperin also doubts that Claimant had an infected knee joint, because the treatment he received would have been inappropriate and could have resulted in damage to the knee. The record shows that when Claimant returned to Bogotá, he received antibiotics for the infection, but the record includes no evidence that any physician evaluated the severity, extent, the precise location of the active infection, or how deeply the infection had spread at the time. Further, although the

antibiotic he was given would not be the drug or treatment of choice Dr. Halperin would employ for an infection in the knee joint, and Dr. Halperin believes it would "not likely" clear it up; he acknowledged that such treatment, if used for a knee joint infection, would leave the knee damaged. Claimant currently manifests knee damage.

Moreover, as previously noted, the work environment of Claimant's job strictly limited his medical options. Indeed, the medical attention he received was provided by the Employer's search and rescue supervisor, and the record does not indicate that he is a physician. Thus, any inference that Claimant's condition was properly diagnosed at the time or that he was given the correct antibiotic for his condition is unfounded. Accordingly, there is no credible basis for the inference Dr. Halperin employs to conclude that Claimant's knee joint was not infected because the treatment provided would have been incorrect, ineffective, or would have caused damage. Furthermore, when Claimant returned home, he continued to follow the treatment plan he was given. While the antibiotic he received may been medically inappropriate, and could have caused knee damage, Claimant acted reasonably in taking the medication recommended by the provider both he and the Employer relied to render the treatment.

Finally, although Dr. Halperin suggested that Claimant's current condition was most likely due to a pre-existing trauma to his right knee, he did not refute Dr. Melton's opinion that, assuming Claimant had any pre-existing right knee damage, it was asymptomatic before January 5, 2004, and was aggravated by the work-related injury. *See*, Uglesich v. Stevedoring Services of America, 24 BRBS 180 (1991). Consequently, for all of the foregoing reasons, I find Dr. Halperin's etiology assessment unpersuasive.

Medical History Evidence

Dyncorp emphasizes, however, that Dr. Melton relied heavily upon Claimant's history in assessing the etiology of his condition. This, of course, is the inevitable consequence under circumstances such these. Indeed, the attention Claimant requested from the Employer was not forthcoming initially, and any contemporaneous physical evaluations or findings rendered by the medical personnel Employer eventually provided have not been documented in this record. As a result, neither Dr. Melton nor Dr. Halperin had the benefit of a professional, contemporaneous assessment of the nature, severity, or precise location of the

infection and/or the spread of the envenonmation[3] which was treated in Bogotá. Thus, Dr. Melton agreed with Dr. Halperin that an articular defect like Claimant's is usually caused by severe trauma; however, in the absence of any history of trauma at all to the right knee, and in the absence of any symptoms in the right knee before the industrial accident, Dr. Melton, relying, in part, on this negative medical history, and the nature of the January 5, 2004 incident and subsequent insect bites and infection, attributed Claimant's condition to the industrial accident.

Relevance of a Negative Medical History

I am, of course, mindful that Employer is critical of the methodology Dr. Melton employed in formulating his etiology assessment. Employer believes he relied too heavily on the absence of any right knee injury history prior to the accident. Like Dr. Halperin, however, Dr. Melton relied on the results of his examination, x-rays, and MRI data, a somewhat more careful review of Claimant's description of his injury and symptoms; and, whereas Dr. Halperin was inclined to attribute Claimant's condition to a pre-existing injury which the evidence does not support, Dr. Melton relied upon the absence of any pre-January 5, 2004 right knee complaints or symptoms which the evidence does support. With no history of any pre-existing right knee trauma and no report of any pre-existing right knee symptoms or complaints of any sort, the negative evidence supports Dr. Melton's opinion, not Dr. Halperin's. Indeed, accepting Dr. Halperin's description of the type of trauma usually associated with an articular defect like Claimant's, the absence of any injury report in Claimant's historical record and the absence of any pre-existing symptoms or complaints for a condition Dr. Halperin described as exceedingly painful, tends to support Dr. Melton's analysis of a direct etiology to the January 5, 2004 incident, if not an aggravation.

Further, Employer understates the importance of a negative pre-injury medical history which supplements the positive medical evidence. The Board has consistently relied upon both lay evidence, *see*, Delay v. Jones Washington Stevedoring Co., 31 BRBS 197 (1998), and medical opinions that cite a pre-injury absence of symptoms as a relevant and substantial factor a physician may rely upon in determining the causation of an injury. In Williams v. Nicole Enterprises, Inc., 19 BRBS 66 (1986), for example, the Board affirmed a finding of causation under circumstances in which there was no evidence of an injury prior to the one at

[3] Record also suggests envenomation by spider bite. Dr. Melton diagnosed synovitis/cellulites of the right knee due to spider bites, but no expert on this record evaluated the pathophysiology of the different venoms administered by the various indigenous arachnids populating the jungle habitat where Walden worked.

issue or of a subsequent fall that could account for a herniated disc. Conversely, in Universal Maritime Corp. v. Moore, 126 F.3d 256, (4th Cir. 1997), negative evidence of the absence of complaints for six months following an injury severed a causal link. *See also*, Holmes v. Universal Maritime Service Corp., 29 BRBS 18 (1995).

Thus, it is not, as the Employer suggests, that the pre-injury absence of symptoms "speaks for itself" in establishing the cause of an injury or disease, but a negative symptom history is clearly relevant, and may be a key factor; particularly when the injury is of a type that ordinarily would trigger symptoms a claimant would not likely be able to overlook, and especially when the importance of the negative evidence is evaluated by a medical expert. Williams v. Nicole Enterprises, Inc., *supra*; Indeed in a correlative analysis, the Board has held that the accuracy of the medical history a physician relies upon is a factor in assessing the evidentiary weight the medical opinion may be accorded. *See generally*, Worhach *v.* Director, *OWCP*, 17 B.L.R. 1-105 (1993)(per curiam); Trumbo *v.* Reading Anthracite Co., 17 B.L.R. 1-85 (1993).

Considering the factors relied upon by both Dr. Halperin and Dr. Melton, I have, for all of the foregoing reasons, accorded Dr. Melton's evaluation of the etiology of Claimant's condition greater weight than the contrary assessment by Dr. Halperin. Accordingly, I conclude that Claimant's current right knee condition is causally related to his January 5, 2004 injury at work.

Impairment Rating

The record shows that Claimant has returned to his usual job as an armament technician without physical limitations or restrictions, and as a consequence, the schedule applies. For purposes of assigning him an impairment rating, the parties have stipulated that the AMA Guide 5th Edition is applicable in this proceeding. Before the agreement was reached, however, Dr. Melton had rated Claimant under the Florida Guides, and the AMA Guides 4th Edition. At his deposition, he revised his impairment rating based upon the AMA Guides, 5th Edition, and that is the rating which we consider here.

Dr. Melton's 60% Impairment Rating

The record shows that in rating Claimant's impairment, Dr. Melton initially referred to the table related to arthritis induced cartilage intervals that, in his opinion, provided a situation analogous to Claimant's. He explained that the table

addresses the thickness of cartilage or the distance between bones. He explained further that he applied this guide because the MRI and the grating of the knee he detected on clinical examination showed that "two bony surfaces within the crater of the chondromalacia…were rubbing against each other," and at that point had basically a zero millimeter interval. He acknowledged that he did not initially discuss the narrowing of the cartilage when he first reviewed the MRI, but he explained that the issue of narrowing "is strictly to try to apply the guides," and that the chondromalacia defect noted on the MRI usually means the cartilage surface is "totally eroded' in the area of the defect. In this instance, Dr. Melton noted that it produced bone on bone contact on one side where there is an absence of cartilage between the lateral femoral condyle and the patella, but he acknowledged that it did not involve the entire knee joint.

Dr. Melton observed that the AMA Guides are not exact, and in many cases, such as this situation, they require the practitioner to extrapolate from the Guide a diagnosis that most closely approximates the condition the patient presents. At one point, in searching for a condition close to Claimant's, he considered analogizing it to a total menisectomy, but eventually decided that the table he actually used most closely approximates Claimant's condition. As a result, he concluded that Walden has a 50% impairment of the lower extremity as a result of the zero cartilage interval due to the articular defect and a 20% impairment due to the patellofemoral joint problem, for a combined 60% impairment rating.

Dr. Halperin's 0% Impairment Rating

On June 21, 2005, Dr. Halperin was deposed. Commenting on Dr. Melton's impairment rating, Dr. Halperin considered it "inappropriate," and based on the wrong AMA Guide. Relying on the AMA Guide 5th edition, Table 17-33, he argued that he could justify a zero impairment rating. He noted that the 5th Edition provides a diagnosis-based ratings system, not ratings based on diminished motion, diminished strength, or diminished ability to function. While the latter considerations are factors usually associated with an injured worker's ability to earn a living, the parties, nevertheless, stipulated that the 5th Edition is the applicable Guide in this proceeding; and Dr. Halperin argued that the Guide has no rating specifically assigned to Claimant's diagnosis. Consequently, he contends Walden's rating arguably should be zero.

In this respect, I believe Dr. Halperin's interpretation, that the absence of a specific rating for a specific diagnosis requires a zero rating for that diagnosis, is a bit too restrictive. The Guides make no attempt to rate every conceivable diagnosis

which may be associated with a physical impairment, and just as the diagnosis itself depends upon the skill and judgment of the practitioner, so too does the appropriate application of the guides. In this instance, I conclude that the absence of a specific rating for a diagnosis of the bone-on-bone contact between the femur and the patella, does not, as Dr. Halperin suggests, require the assignment of a zero impairment rating under the Guides. I find nothing in the Guides to suggest they were meant to supersede the judgment of the practitioner who finds that an impairment may nevertheless be present. Nor were they meant to be applied, as Employer suggests, quite so literally and mechanically as to deny ratings for impairments caused by conditions not mentioned.

Dr. Halperin's 7% Impairment Rating

Indeed, Dr. Halperin, perhaps anticipating that a wooden application of the Guides might be problematic, employed his expertise and applied the Guides to Claimant's situation. He agreed with Dr. Melton that the Guides do not specifically address Claimant's condition, but he believes the Table Dr. Melton used for a patella subluxation with residual instability was incorrectly invoked and evaluates a condition which is worse than Claimant's defect. Dr. Halperin further disagreed with Dr. Melton's rating which combined the knee and patellofemoral joint. In his opinion, if you rate the knee at the maximum, the patellofemoral joint should not be rated separately, but he acknowledged that others may disagree. Assuming, however, the two are combined for a zero millimeter interval, he agreed the combined 50% and 20% on the combination chart equates to a 60% rating. Nevertheless, in Dr. Halperin opinion, using what he considers the correct table, Table 17-33, of the AMA Guide 5th edition, Claimant has, at most, a 3% whole person impairment and 7% impairment of the right lower extremity.

While I have accepted and accorded Dr. Melton's etiology evaluation greater weight than Dr. Halperin's, I find that Dr. Halperin's impairment rating of 7% for the right lower extremity more accurately reflects the degree of Claimant's impairment than the individual or combined ratings rendered by Dr. Melton. Dr. Halperin noted that Dr. Melton used the Guide for arthritis in the knee, a condition that involves the cartilage between the weight-bearing femur and the tibia, not the femur and the patella which is not in a weight bearing area. Further, he noted that Dr. Melton's rating equated to a total loss of cartilage between the femur and tibia where Claimant's knee is normal. As Dr. Halperin explained, while there is bone on bone contact in the isolated area of erosion at the articular defect, it does not extend across the entire cartilage as Dr. Melton's rating assumes. In addition, when factors which may be extraneous to the Guides, but clearly important in evaluating

the vocational impact of an injury are considered, Dr. Halperin's reasoning is confirmed.[4]

Thus, the record shows that Claimant has returned to work at his usual job. While this would not prevent the application of the schedule,[5] it is a factor in assessing the degree of impairment, especially under circumstances in which the residuals of a permanent condition include no permanent physical restrictions. Here, for example, Dr. Halperin found on physical examination that the articular defect produced no decrease in Claimant's range of motion, no atrophy, no loss of strength, no gait derangement, no nerve damage, and does not limit his activities. These findings, moreover, are not dissimilar to those reported by Dr. Melton during his July 20, 2004 examination, when he noticed crepitus under the patella, but he observed that Claimant has a normal gait and has no problem getting up and down from a seated position.

For all of the foregoing reasons, I find and conclude that Dr. Halperin has provided a more comprehensive and better reasoned evaluation of Claimant's impairment than Dr. Melton, and, accordingly, I have accorded Dr. Halperin's impairment rating of 7% for the right lower extremity greater evidentiary weight than the impairment ratings formulated by Dr. Melton. In summary, having relied upon Dr. Melton's etiology assessment and Dr. Halperin's impairment rating, I conclude that Claimant has sustained a 7% work-related scheduled permanent partial disability to his right lower extremity. Therefore:

[4] The 1984 Amendments to the Act require that hearing loss impairments be measured in accordance with the Guides to the Evaluation of Permanent Impairment of the American Medical Association, See 33 U.S.C. § 908(13)(E), but for other impairments, the Board has held that the trier of fact has discretion to accept or reject medical testimony, and that discretion applies to the utilization of the A.M.A. Guides in determining scheduled disabilities. Robinson v. Bethlehem Steel Corp., 3 BRBS 495 (1976); Fisher v. Strachan Shipping Co., 8 BRBS 578 (1978); Jones v. I.T.O. Corp. of Baltimore, 9 BRBS 583 (1979).

[5] It should be noted that whether or not Claimant has lost any wage earning capacity is here irrelevant. So long as he is not totally disabled, the schedule applies. *See*, Pepco v. Director, 449 U.S. 268, 273,281-83 (1980); Gilchrist v. Newport News Shipbuilding and Drydock Co,

Order

IT IS ORDERED that the Employer pay Claimant compensation based upon an average weekly wage of $1,183.39 for a seven percent permanent partial impairment to the right lower extremity in accordance with Section 8(c)(2) of the Schedule, and shall further provide all medical benefits reasonably necessary for the care and treatment of Claimant's work-related injury.

A

Stuart A. Levin
Administrative Law Judge